Appendix 22
SAMPLE PRIOR AUTHORIZATION DENTAL ATTACHMENT REQUEST FORM (PA/DA)

DENTAL AND ORTHODONTICS PRIOR AUTHORIZATION (PA/DA) FORM
(Attach to PA/DRF form)

WRITE IN P.A. # *(preprinted in red ink on PA/DRF form)*	RECIPIENT'S MEDICAID ID #	BILLING PROVIDER #	PERFORMING PROVIDER # *(If different)*

PA/DA PAGE 1

COMPLETE THIS PAGE FOR ALL DENTAL AND ORTHODONTIC PRIOR AUTHORIZATION REQUESTS

Please answer all questions on this page. If necessary, attach additional pages for your responses.

1. **Complete for all dental services.** Dental diagnosis / Description of present condition:

2. **Complete for Orthodontics .** Type of malocclusion:

3. **Complete for all dental services.** Dental indications, dental history, or medical need pertinent to treatment requested:

4. **Complete for all dental services.** Specific treatment plan:

5. **Complete for Orthodontics.** Anticipated number of monthly adjustments:

6. **Complete for all dental services.** Overall treatment prognosis (circle one)

EXCELLENT	GOOD	FAIR	POOR

If POOR, please explain the reason for the requested treatment.

7. **Complete for all dental services.** Indicate if the recipient is physically, psychologically, otherwise indefinitely disabled, or has a medical condition that impacts the treatment requested.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

Appendix 22
SAMPLE PRIOR AUTHORIZATION DENTAL ATTACHMENT REQUEST FORM (PA/DA)
(continued)

PA/DA PAGE 2

COMPLETE THIS PAGE FOR:

ENDODONTICS (Questions 1, 2, 3, 4, 5, 6 and 8)

PERIODONTICS (Questions 1, 2, 3 and 7)

PARTIAL DENTURES (Questions 1, 2, 3, 8 and 9 – also complete Page 3)

If necessary, attach additional pages for your responses.

1. **Complete for Endodontics, Periodontics, or Partial Dentures.** Condition of caries control:
   - a. Restorative treatment plan has not been started. ☐
   - b. Restorative treatment plan is in progress. ☐
   - c. Restorative treatment plan has been completed. ☐

2. **Complete for Endodontics, Periodontics, or Partial Dentures.** Oral hygiene status (circle one):

EXCELLENT	GOOD	FAIR	POOR

3. **Complete for Endodontics, Periodontics, or Partial Dentures.** Recipient attendance (circle one):

EXCELLENT	GOOD	FAIR	POOR	NEW PATIENT

4. **Complete for Endodontics.** Have recipient provide reasons and estimated dates for any extractions within the past three years.

5. **Complete for Endodontics.** Is the requested tooth an abutment for a partial/bridge?

   Yes ☐ No ☐

   If yes, indicate age and condition of partial/bridge.

6. **Complete for Endodontics.** For endodontic treatment, indicate if the tooth can be restored.

   ☐ I am able to restore the tooth using Medicaid-covered services.

Medicaid does not cover post and core or a permanent crown. If restoration requires the use of services not covered by Medicaid, please indicate whether the recipient has agreed to pay for services necessary to complete the restoration which are not covered by Medicaid.	Yes, the recipient has agreed to pay for restorative services not covered by Medicaid. ☐ No, the recipient has not agreed to pay for restorative services not covered by Medicaid. ☐

7. **Complete for Periodontics.** Describe a comprehensive periodontal treatment plan, including pre- and post-operative care.

8. **Complete for Endodontics or Partial Dentures.** Are all remaining teeth decay-free, properly restored, and periodontally healthy to ensure a good five-year prognosis?

   Yes ☐ No ☐

   If no, please explain restorations in progress.

9. **Complete for Partial Dentures.** If all necessary extractions have not been completed, please explain why.

Appendix 22
SAMPLE PRIOR AUTHORIZATION DENTAL ATTACHMENT REQUEST FORM (PA/DA)
(continued)

DENTAL AND ORTHODONTICS PRIOR AUTHORIZATION (PA/DA) FORM
(Attach to PA/DRF form)

WRITE IN P.A. # *(preprinted in red ink on PA/DRF form)*	RECIPIENT'S MEDICAID ID #	BILLING PROVIDER #	PERFORMING PROVIDER # *(if different)*

PA/DA PAGE 3

COMPLETE THIS PAGE FOR:
PARTIALS
DENTURES

Respond to all applicable questions if the recipient has and/or is requesting a removable complete or partial denture. Mark appropriate boxes.

If necessary, attach additional pages for your responses.

1. Does the recipient have a partial or denture(s)?

   Yes ☐ No ☐

   If yes, *please indicate:*

   Full ☐ Max. ☐ Mand. ☐

   Partial ☐ Max. ☐ Mand. ☐

2. Does the recipient wear his/her partial or denture(s)?

   Yes ☐ No ☐

   If no, answer question 3.

   If yes, *please indicate:*

   Max. ☐ Mand. ☐

3. If the recipient is no longer wearing the partial or denture(s), when did the recipient stop wearing it?

   Max _____ Mand _____

   Reason why the recipient stopped wearing existing partial / denture(s):

4. How old is the existing partial or denture(s)?

   Max _____ Mand _____

   Reason why the partial or denture(s) cannot be relined:

5. If the recipient is edentulous, how long edentulous?

   Max _____ Mand _____

Policy on Lost, Stolen or Severely Damaged Dentures	Documentation for Lost, Stolen or Severely Damaged Dentures
Wisconsin Medicaid does not routinely replace lost, severely damaged, or stolen prostheses. These prior authorization requests are only approved when: • The recipient has exercised reasonable care in maintaining the denture; • The prosthesis was being used up to the time of loss or theft; • The loss or theft is *not* a repeatedly occurring event; • A reasonable explanation is given for the loss or theft of the prosthesis; and • A reasonable plan to prevent future loss is outlined by the recipient or the facility where the recipient lives.	The dentist must attach documentation of the loss of dentures from the appropriate source. Documentation may include: • Police report, accident report, or fire report; • Hospital, nursing home, or group home/community based residential facility administrator statement on the loss; • Recipient statement on the loss.

See Wisconsin Medicaid Provider Handbook, Part B (Dental) for more information.

Appendix 23
PRIOR AUTHORIZATION DENTAL ATTACHMENT REQUEST FORM (PA/DA) COMPLETION GUIDELINES

When completing prior authorization (PA) requests, thoroughly answer all appropriate questions. Provide enough key information for Wisconsin Medicaid dental consultants to make a reasonable judgement about the case. This will decrease the number of resubmissions and prevent denials due to inadequate information.

All dentists requesting PA need to complete the following:

Service requested	Pages to complete
Additional dental visits or cleanings	PA/DRF and PA/DA page 1
Orthodontia	PA/DRF and PA/DA page 1
Endodontics, Periodontics, Partial dentures	PA/DRF and PA/DA pages 1 and 2
Partials, Dentures	PA/DRF and PA/DA pages 1, 2, and 3

Attach the appropriate pages of the completed PA/DA form to the Prior Authorization Dental Request Form (PA/DRF) and submit to the following address:

Prior Authorization Unit
EDS
Suite 88
6406 Bridge Road
Madison WI 53784-0088

HEADER COMPLETION INSTRUCTIONS – ALL PA/DA PAGES

The numeric information in the boxes at the top of each page of the PA/DA form must be completed. This information ensures accurate tracking of the PA/DA form with the PA/DRF form through the PA review process. This form will be returned to you for completion if this numeric information is not provided at the top of each page of the PA/DA form you submit.

DESCRIPTION	INSTRUCTIONS
WRITE IN PA #	Write in the red, preprinted number stamped at the top of the PA/DRF form.
RECIPIENT'S MEDICAID ID #	Enter the recipient's 10-digit Medicaid number exactly as it appears on the Medicaid identification card.
BILLING PROVIDER #	Enter the billing provider's 8-digit Medicaid provider number.
PERFORMING PROVIDER # *(if different)*	The performing provider is the dentist who will actually provide the service. You only need to complete this section if the performing provider is different from the billing provider.

PA/DA COMPLETION INSTRUCTIONS

PAGE 1 — Complete all questions on Page 1 of the PA/DA for all dental or orthodontic PA requests.

PAGE 2 — For endodontic PA requests, complete questions 1, 2, 3, 4, 5, 6, 8.
For periodontic PA requests, complete questions 1, 2, 3, and 7.
For partial denture PA requests, complete questions 1, 2, 3, 8, and 9.

PAGE 3 — Complete all questions on Page 3 for partials and dentures.

Appendix 24
Wisconsin Medicaid Information Needed For Prior Authorization Requests

When completing prior authorization (PA) requests, please:

- Thoroughly answer all appropriate questions.
- Provide all the key information about the recipient's case.
- Give enough information for Wisconsin Medicaid dental consultants to make a reasonable judgment about the request. This is the only information they have on which to base their decision.

Careful completion of all necessary PA questions will:

- Decrease the number of resubmissions.
- Prevent denials due to inadequate information.

ADA PROCEDURE CODE	SERVICE	INFORMATION NEEDED
Preventive Services		
01351	Sealants	PA required for most teeth but not required for first and second permanent molars.
01515	Space maintainer	Two bitewing x-rays (PA required ages 13-20).
Restorative Services		
02932, 02933	Composite/prefabricated resin crown, prefabricated stainless steel crown with resin window	One periapical x-ray (PA required for adults over age 20 only).
W7126	Upgraded crown	One periapical x-ray.
Endodontic Services		
03310, 03320, 03330	Anterior, bicuspid, and molar root canal therapy	- One periapical x-ray. - Two bitewing x-rays. - Intraoral charting (PA/DRF Element 17). (PA always required for adults over age 20 on all teeth and for children on molar teeth.)
03410	Apicoectomy (anterior only)	- One periapical x-ray.
03430	Retrograde filling	- One periapical x-ray.
Periodontic Service		
04341	Periodontal scaling and root planing	- Periodontal charting.
04355	Full mouth debridement	- Periodontal charting. - Minimum of 4 bitewing x-rays or a full mouth x-ray.
04910	Periodontal maintenance	- Periodontal charting.

ADA PROCEDURE CODE	SERVICE	INFORMATION NEEDED
Prosthodontic Services		
05110-05120	Denture	- If replacing lost/stolen prosthesis, include official explanation of loss and a plan to prevent future loss.
05211-05212 W7127-W7128	Partial denture Upgraded partial denture	- X-rays sufficient to show entire arch plus bitewings, if appropriate. - Periodontal charting. - Intraoral charting (PA/DRF Element 17). - If replacing lost/stolen prosthesis, include official explanation of loss and a plan to prevent future loss.
05955	Palatal lift	- If replacing lost/stolen prosthesis, include official explanation of loss and a plan to prevent future loss. - Physician or speech pathologist statement documenting speech impediment.
Fixed Prosthodontic Services		
06545, 06940-06980 W7310-W7320	Fixed prosthodontics	- Periapical x-rays sufficient to show treatment area. - Periodontal charting of abutment teeth.
Oral and Maxillofacial Surgery Services		
07280-07281	Surgical exposure	- One periapical x-ray. - HealthCheck referral.
07530-07540 and equivalent CPT codes	Removal foreign body	- One periapical x-ray. (PA not required for POS 1 or in an emergency.)
07840-07860, 07950, 07991 07992 and equivalent CPT codes	TMJ surgery	- TMJ second surgical opinion. - Document non-surgical treatment. - Operative and post-op plan of care. - X-ray report.
07940, 07960 and equivalent CPT codes	Orthognathic surgery, frenulectomy	- HealthCheck.
Orthodontic Services		
08110-08750 W7910-W7920 00340	Orthodontic service	- HealthCheck referral. - Study models. Pack study models securely in packing material to prevent breakage.

All PA requests require:

- A statement from the dentist regarding the reasons for the requested treatment.
- Answers to all appropriate questions on all PA forms.
- Signatures and dates on each form.

When appropriate, include the following information:

- A description of the recipient's oral health.
- Any physical or mental disability that affects the recipient's dental health and hygiene.
- Any state/federal law that requires the recipient to receive treatment (such as when a child is in foster care).
- Any medical condition that affects the recipient's dental health.
- The relationship between the prior authorized treatment and other dental treatment in progress.
- Trauma situations that have affected the treatment needed.
- Efforts to date to correct the problem.
- Additional X-rays or intraoral pictures if they are needed to better document the situation.

Appendix 25
Provision of Upgraded Partial Denture and Crowns to Medicaid Recipients

A dentist/dental clinic must submit the following form or another written document with the same information upon submission of the first prior authorization (PA) request to provide an upgraded partial denture and/or crown (higher quality than currently covered by Medicaid) to a Medicaid recipient. All subsequent PA requests to provide an upgraded crown or partial denture *under the same dental clinic/dentist provider number* must either contain the same form or reference as the previously submitted document.

1. All Medicaid patients who receive services from the dentist/dental clinic listed below are eligible to receive upgraded crowns and/or partial dentures based on the following medical criteria established by the dental office:

2. All Medicaid recipients who receive upgraded crowns and/or partial dentures are charged no more than $3 copayment, unless the recipient is exempt from copayment charges as based on Medicaid copayment exemptions outlined in Part A, the all-provider handbook.

3. Medicaid payment along with the $3 recipient copayment is accepted as payment in full for the upgraded procedures.

Dentist/Dental Clinic (printed)_____

Dentist/Dental Clinic (signature)_____

Medicaid Provider Number _____ Date _____